Clinical microbiological case: severe relapsing septal panniculitis in a healthy man from the south-eastern USA

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CASE REPORT

A 34-year-old, healthy caucasian man presented with relapsing, painful nodular lesions involving both the upper and lower extremities. His symptoms commenced eight weeks after burying two domestic cats that had died suddenly. He complained of profound fatigue, generalized myalgia, and joint pain, although he denied having cough, fever, and night sweats. An 8-cm arciform lesion on the anterior–medial aspect of the right upper arm had bright erythematous borders and a violaceous center. He was afebrile with small, nontender, generalized lymphadenopathy. Ophthalmologic examination was normal. His white blood cell count was 11 700 cells/μL and his platelet count was 388 000 /μL. Serum aminotransferase and ACE levels, and erythrocyte sedimentation rate were normal. His symptoms worsened after two weeks of oral methylprednisolone and cefuroxime axetil (500 mg twice daily) treatment.

Histologic examination of the right arm lesion showed severe panniculitis with prominent necrosis of subcutaneous fat (Figure 1). Stains for acid-fast bacilli (Ziehl–Neelsen), fungi (GMS), and bacteria (Brown–Hopps, Brown–Brenn), and Warthin–Starry stain, were negative. Blood and tissue cultures were sterile. CT scan showed a normal liver, spleen, and intrathoracic and abdominal lymph nodes. A whole-body gallium scan was normal.

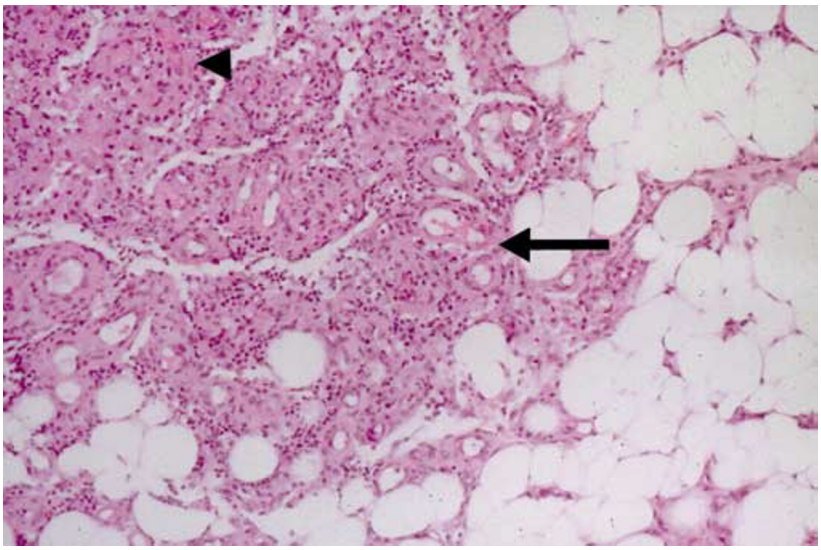

Figure 1 Extensive fat necrosis and septal panniculitis is observed (H&E, magnification ×100). There is no evidence of inflammatory infiltrates including histiocytes around small intralobular venules (arrow) or arteriole (arrow head).

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QUESTIONS

1. What is your clinical diagnosis?
2. What are the common diseases associated with this infection?
3. What cutaneous manifestations are frequently seen in this setting?
4. What is the optimal treatment?